CITY OF RIVERSIDE DENTAL BENEFITS ENROLLMENT/CHANGE FORM

Name of Subscriber: Last **First** **M.I.** **Social Security No.**

Address **City** **State** **Zip**

Department/Division **Hire Date** **Work Phone** **Home Phone**

Bargaining Unit Name **City Employee ID Number**

Birth Date:_____

Sex: Male Female

Marital Status (Circle One)

Single Married Divorce

Marriage/Divorce Date:

_____

Indicate actions that apply:

- ☐ New Enrollment
- ☐ Active Employee
- ☐ Retiree
- ☐ Cobra
- ☐ Edit Name/Address
- ☐ Student Status
- ☐ Delete Dependent
- ☐ Add Dependent
- ☐ Open Enrollment
- ☐ Change Dental Office
- ☐ Cancel Coverage Eff._____
- ☐ Other _____

Choose Your Dental Plan (Select One)

- ☐ Deltacare PMI/DHMO Plan # 00898-_____
- ☐ Delta DPO Dental Plan # 0642-_____
- ☐ Local Advantage Dental Plan # _____

HR ONLY

If dependent(s) have a different address, please indicate. <u>If you have a college age dependent this entire section must be completed.*</u>

Student/Dependent Name Address City State Zip

Name of Institution **Address** **City** **State** **Zip** **<u># of Units</u>**

Do any dependents have other dental insurance? If yes, please complete:

Dependent's Name Insurance Company Name Policy No.

List Eligible Person(s) to be Covered OR Person(s) to be Deleted

Relationship	Last Name First M.I.	Social Security No.	Birth Date	Age	Dental Office Code**	Dental Office Name and Address	Existing Patient
☐ **Self**							☐ Yes ☐ No
☐ **Spouse** ☐ **Domestic Partner**							☐ Yes ☐ No
☐ **Son** ☐ **Daughter**							☐ Yes ☐ No
☐ **Son** ☐ **Daughter**							☐ Yes ☐ No
☐ **Son** ☐ **Daughter**							☐ Yes ☐ No
☐ **Son** ☐ **Daughter**							☐ Yes ☐ No

*Must be completed for Overage Dependent who are 19 years of age and over. **Dental Office Code must be filled in for Deltacare PMI/DHMO.

Enrollment Agreement and Payroll Deduction Authorization

I acknowledge that the above information represents my enrollment choice(s). I understand my coverage elections cannot be changed until a future benefits enrollment period. I represent that to the best of my knowledge and belief, all statements and answers made on this form are true and complete. If applicable, I authorize any insurance company, hospital, physician, or any other health care provider to release all information to all those who may have a bearing on benefits available under this plan. Adjustments may be made to increase or decrease the amounts specified for deductions by the City, provided that the method, manner and amount of such deductions are in full compliance with applicable laws and administrative rules and regulations of the City. The employee portion of the deduction will be automatically deducted pre-taxed on a biweekly basis (This excludes Domestic Partner participants). If I am adding a domestic partner, I will provide a copy of the "Declaration of Domestic Partnership" which can be provided by the Secretary of State, in order for my domestic partner to be eligible for benefits.

I understand and agree to the terms and conditions described above.

Employee Signature Date

Original/Insurance Co. Yellow/Employer Pink/Employee